2017
HEALTH COVERAGE ENROLLMENT/CHANGE FORM

ROUND ROCK TEXAS
HUMAN RESOURCES

Humana presents Austin Business Journal's HEALTHIEST EMPLOYERS OF CENTRAL TEXAS

PERSONAL INFORMATION

Employee's Name (Last, First, MI)	Social Security Number	Date of Birth	Sex M ☐ F ☐

Employee's Address (Street, No.) City State Zip	Home Phone	Employee No:

Job Title	Hire Date	Department	Email Address:	Coverage Effective Date:

REASON FOR CHANGE: ☐ Marriage ☐ Divorce ☐ Birth ☐ Adoption ☐ Loss of Coverage

COVERAGE ELECTIONS (Per Pay Period Amount Shown) *24 Payroll Deductions Per Year*

☐ I DECLINE ALL MEDICAL, DENTAL AND VISION COVERAGE (*Complete Proof of Other Coverage Section Below*)

Aetna Basic Medical		Aetna Whole Health-Seton Plan		Aetna Dental Plan		Aetna Vision Plan	
☐ Employee Only	$ 70.00	☐ Employee Only	$ 52.50	☐ Employee Only	$ 10.00	☐ Employee Only	$ 0.00
☐ Employee & Child(ren)	$ 175.00	☐ Employee & Child(ren)	$ 140.00	☐ Employee & Spouse	$ 18.00	☐ Employee & Spouse	$ 2.78
☐ Employee & Family	$ 245.00	☐ Employee & Family	$ 205.00	☐ Employee & Child(ren)	$ 17.00	☐ Employee & Child(ren)	$ 2.49
				☐ Employee & Family	$ 31.00	☐ Employee & Family	$ 5.49

☐ ADD ☐ DELETE Provide the following information for each dependent that should be insured for any of the above elections.

Coverage Selection		Last Name (if different from employee name)	First Name	MI.	Sex M F	Date of Birth	Social Security Number
☐ Medical ☐ Dental ☐ Vision	Spouse				☐ ☐		
☐ Medical ☐ Dental ☐ Vision	Child				☐ ☐		
☐ Medical ☐ Dental ☐ Vision	Child				☐ ☐		
☐ Medical ☐ Dental ☐ Vision	Child				☐ ☐		
☐ Medical ☐ Dental ☐ Vision	Child				☐ ☐		

PROOF OF OTHER COVERAGE

Are you, or any dependents covered for medical, dental or vision care benefits through another plan? ☐ Yes ☐ No

If yes, name of Employer or Plan: Type? ☐ Medical ☐ Dental ☐ Vision

Group, Plan or Policy Number: Who is covered? ☐ Yourself ☐ Spouse ☐ Child(ren)

Long-Term Disability: Provides 60% of monthly income if totally disabled.– Aetna (*City Paid, No Deductions*)

☒ Automatically enrolled at no cost to employees who work thirty (30) hours or more per week.

Term Life Insurance for Active Employees 1 X Annual Salary (Maximum Benefit $100,000) – Aetna *(City Paid, No Deductions)*

☒ Automatically enrolled at no cost to employees who work thirty (30) hours or more per week.

VOLUNTARY BENEFITS *24 Payroll Deductions Per Year*

1.Short-Term Disability - Issued by Aetna (24 Payroll Deductions Per Year)

☐ Yes, I would like to enroll ☐ 13 Weeks ☐ 25 Weeks ☐ No, I decline to enroll at this time. Deduction per Payroll: $ _____

2. Voluntary Term Life Insurance - Issued by Aetna Life Insurance (24 Payroll Deductions Per Year)

This is in addition to the life insurance and supplemental death benefit provided by the City.

☐ Employee Life Amount: $ _____
☐ Spouse Life Amount: $_____
☐ Child Life: $ 10,000

Deduction per Pay Period
Employee: $_____
Spouse: $_____
Child(ren) $_____
TOTAL $_____

BENEFICIARY DESIGNATION (This Section Must Be Completed for ALL Life/AD&D Insurance)

Name	Address	%	Relationship	Social Security Number

3. Voluntary Accident Insurance – Abacus Group (24 Payroll Deductions per year)

☐ Yes, I would like to enroll. ☐ Option B ($50 Wellness Benefit) ☐ Option C ($100 Wellness Benefit)

. ☐ No, I decline to enroll at this time.

Deduction per Pay Period
Employee (EE): $_____
EE + Child(ren) $_____
EE + Spouse $_____
Family: $_____

4. Voluntary Critical Illness Insurance – Abacus Group (24 Payroll Deductions per year)

☐ Yes, I would like to enroll. ☐ No, I decline to enroll at this time.

Employee Uses Tobacco: ☐ Yes ☐ No Spouse Uses Tobacco: ☐ Yes ☐ No

Deduction per Pay Period
Employee: $_____
EE + Spouse $_____

FLEXIBLE SPENDING ACCOUNT(S) – Contributions *24 Payroll Deductions Per Year*

Employees who do not work a full twelve months will have deductions taken out during the months they are actively employed and prorated according to the total amount of the premium. (e.g.: If total annual premium is $99.00, and work nine months, there would be 18 deduction periods. Deduction would be $5.50 [$99/18 deduction periods = $5.50]).

I ELECT to participate in the Flexible Spending Account(s).

☐ Medical FSA Per Pay Period Amount: $ X 24 Pay Periods = $ Annual Amount

☐ Dependent Care FSA Per Pay Period Amount: $ X 24 Pay Periods = $ Annual Amount

EMPLOYEE SIGNATURE

✕ _____ _____
Employee Signature Date